



Unum Life Insurance Company of America  
Portland, Maine 04122

**Election for Continuation of Coverage- A  
Long Term Care**

Mail to: Unum LTC Customer Services  
2211 Congress Street  
Portland, Maine 04122-1760

**Continuation Number:**

**To be completed by the Employer**

Company Data:	<i>Company Name</i>	<i>Plan Number</i>	
Company Address:	<i>Street</i>	<i>City</i>	<i>State/Zip</i>
Employee Name:	<i>Last Name</i>	<i>First Name</i>	<i>Middle Initial</i>
Employee Data:	<i>Date of Birth</i>	<i>Social Security Number</i>	<input type="checkbox"/> Male <input type="checkbox"/> Female
Person terminating group coverage:	<i>Name(s)</i>	<input type="checkbox"/> Employee <input type="checkbox"/> Family Member	
Reason person is terminating group coverage:	<input type="checkbox"/> Termination of Employment <input type="checkbox"/> Divorce	<input type="checkbox"/> Death of Spouse <input type="checkbox"/> Other _____	
Date group coverage terminates:	<i>Month</i>	<i>Day</i>	<i>Year</i>
Current monthly premium payment:	<i>Employee</i> \$/month	<i>Family Member</i> \$/month	

**Signature of Employer:**

**Date:**

**To be completed by the Employee**

If you are an insured employee, you may be eligible for continuation of your Long Term Care Insurance after your group coverage terminates. If you wish to elect continuation of coverage, complete this section and send this form to Unum within 31 days after your group coverage terminates. You must include your first premium payment, which is based on the payment option you select below. **You will be responsible for the entire cost of your coverage.**

Mailing Address:	<i>Street</i>	<i>City</i>	<i>State/Zip</i>
Payment Options:	<input type="checkbox"/> Quarterly <input type="checkbox"/> (3x monthly rate)	<input type="checkbox"/> Semi-Annually <input type="checkbox"/> (6x monthly rate)	<input type="checkbox"/> Annually <input type="checkbox"/> (12x monthly rate)

**Signature of Employee:**

**Date:**

**To be completed by the Employee's Family Member**

If you are the insured family member or former family member of the above employee, you may be eligible for continuation of your Long Term Care Insurance after your group coverage terminates. If you wish to elect continuation of coverage, please complete this section and send this form to Unum within 31 days after your group coverage terminates. You must include your first premium payment, which is based on the payment option you select below. **You will be responsible for the entire cost of your coverage.**

Name:	<i>Last Name</i>	<i>First Name</i>	<i>Middle Initial</i>
Mailing Address:	<i>Street</i>	<i>City</i>	<i>State/Zip</i>
Data:	<i>Date of Birth</i>	<i>Social Security Number</i>	<input type="checkbox"/> Male <input type="checkbox"/> Female
Payment Options:	<input type="checkbox"/> Quarterly <input type="checkbox"/> (3x monthly rate)	<input type="checkbox"/> Semi-Annually <input type="checkbox"/> (6x monthly rate)	<input type="checkbox"/> Annually <input type="checkbox"/> (12x monthly rate)

**Signature of Employee's Family Member:**

**Date:**

## **Information About Continuation Coverage**

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### **Should The Certificate of Insurance be Kept?**

If continuation of coverage is elected, you will not receive a new Continuation Certificate of Insurance. The coverage you or your family member had under the group plan continues under continuation of coverage.

### **Can Coverage Be Changed?**

You or your family member may apply at any time to increase coverage by filling out a new application, which includes evidence of insurability. Call Unum at (800) 227-4165 for assistance.

### **When Are Premiums Due and What Is The Grace Period?**

Premium payment options include quarterly, semi-annually, or annually. Mail the first premium payment with this form. Unum will mail subsequent bills to you or your family member at the address(es) provided. A grace period of 45 days after the premium due date will be allowed for the payment of each premium.

### **Where Should Premium Payments Be Sent?**

You or your family member must pay the premium directly to Unum for coverage to be continued. The address is:

Unum LTC Customer Services  
2211 Congress Street  
Portland, Maine 04122-1760

### **How Long Will Unum Continue To Pay For Long Term Care Benefits?**

Unum will continue monthly payments for long term care benefits until the earliest of the following dates:

- The date the person is no longer disabled,
- The date the person dies, or
- The date the person's total benefit payments equal the lifetime maximum amount.

### **When Will This Continuation of Coverage Terminate?**

A person's continuation of coverage will terminate on the earlier of:

- The end of the period for which the required premiums for the continuation of coverage were last paid to Unum, or
- The date the person dies.



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Employee Name:	<i>Last Name</i>	<i>First Name</i>	<i>Middle Initial</i>
Employee Data:	<i>Date of Birth</i>	<i>Social Security Number</i>	<input type="checkbox"/> Male <input type="checkbox"/> Female
Person terminating group coverage:		<i>Name(s)</i>	<input type="checkbox"/> Employee <input type="checkbox"/> Family Member
Reason person is terminating group coverage:		<input type="checkbox"/> Termination of Employment <input type="checkbox"/> Divorce	<input type="checkbox"/> Death of Spouse <input type="checkbox"/> Other _____
Date group coverage terminates:		<i>Month Day Year</i>	
Current monthly premium payment:		<i>Employee</i> \$ /month	<i>Family Member</i> \$ /month

**Signature of Employer:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**To be completed by the Employee**

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Mailing Address:	<i>Street</i>	<i>City</i>	<i>State/Zip</i>
Data:	<i>Date of Birth</i>	<i>Social Security Number</i>	<input type="checkbox"/> Male <input type="checkbox"/> Female
Payment Options:	<input type="checkbox"/> Quarterly <input type="checkbox"/> (3x monthly rate)	<input type="checkbox"/> Semi-Annually <input type="checkbox"/> (6x monthly rate)	<input type="checkbox"/> Annually <input type="checkbox"/> (12x monthly rate)

**Signature of Employee's Family Member:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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